Statement of

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Incident Command, Control, and Communications during Catastrophic Events

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"Incident Command, Control, and Communications during Catastrophic Events"

I. Introduction

Chairman Reichert, Ranking Member Pascrell and members of the Subcommittee on Emergency Preparedness, Science and Technology, I greatly appreciate the opportunity to speak before you today.

I am Robert L. Garner, and currently serve as the President of the American Ambulance Association (AAA). I am the Senior Vice President of Emergency Medical Services Corporation, parent company of American Medical Response and EmCare companies, national providers of emergency and non-emergency ambulance services as well as hospital physician services.

The American Ambulance Association is the primary trade association representing agencies that provide emergency and non-emergency ambulance services for their respective communities. The AAA is composed of over 750 ambulance operations providing services in all 50 states. Member companies employ approximately 100,000 paramedics and emergency medical technicians (EMT) and in their workforce. AAA members include private, public, fire and hospital-based providers covering urban, suburban, and rural areas throughout America. The AAA was formed in 1979 in response to the need for improvements in medical transportation and emergency medical services. The Association serves as a voice and clearinghouse for ambulance service providers who view pre-hospital care not only as a public service but also as an essential part of the total continuum of care in the public heath care system.

It is in my elected role as President of the AAA that I appear before you today, and provide the perspective of the Association regarding "Incident Command, Control, and Communication during Catastrophic Events."

II. Summary of Policy Recommendations

Ambulance service providers, who are comprised of paramedics and emergency medical technicians, serve as a core part of the first responder's community and are a critical part of the emergency response system. However, private providers often face difficulty in being included in the planning and response to catastrophic events and obtaining the funding necessary to be prepared when they are asked to respond. To ensure that all ambulance service providers are effectively integrated in to the National Incident Management System, I recommend the following:

- Integrate government and non-government emergency medical service providers into local, state and federal planning and exercises including appropriate mutual aid agreements;
- Ensure government and non-government emergency medical service providers are eligible have access to communications equipment and systems to achieve on scene communications interoperability; and,

- Ensure government and non-government service emergency medical service providers have access to the appropriate personal protective equipment and other on scene resources necessary to support their critical public safety missions including evacuation and response.

III. Role of Ambulance Service Providers as First Responder

The immediate response to a catastrophic disaster, act of terrorism or other public health emergency involves many local public safety, public health and health care organizations. As first responders, America's ambulance service providers are an essential resource and perform vital services as part of each community's emergency response system. This was abundantly clear during the recent response to Hurricanes Katrina and Rita in which over five hundred ambulances, comprised of paramedics and emergency medical technicians, from around the country assisted local EMS agencies in their response to the catastrophic events along the gulf coast.

During the response to a natural or man-made disaster, the role of an ambulance service provider includes patient triage, decontamination, treatment, and transport. Their role also includes hazard recognition, symptom surveillance and reporting, disaster shelter staffing and re-supply, on-scene medical stand-by, and transport and redistribution of patients to better utilize available receiving hospital resources. Many agencies have begun developing "disaster response teams" to effect rapid deployment in support of local, state and federal resources.

America's 9-1-1 emergency medical services (EMS) providers are a diverse group of public, private, hospital and volunteer-based services. Indeed, many stories of heroism and sacrifice include representatives from all these agencies as they have responded to natural and man-made disasters. Notably, just two weeks ago, President Bush posthumously awarded Yamel Merino, a paramedic with TransCare Ambulance Service of New York, the 9/11 Heroes Medal of Valor. Indeed, each day somewhere in America, an EMT or Paramedic may be placed in harm's way to potentially save another's life.

During a catastrophic disaster or "Event of High Consequence," local ambulance services providing emergency medical services are an essential resource and a vital part of the emergency response system. In a review of the nation's largest 200 cities, including those most vulnerable to attack, emergency ambulance services are provided by private, public, volunteer, and hospital-based agencies. Experience has shown that non-emergency ambulance providers also often serve as "first responders" by dedicating essential vehicle and personnel resources within the first hours of a disaster.

IV. Importance of Private-Public Partnerships

Unlike fire and police, which are typically public sector entities, the private sector is a major provider of emergency and non-emergency medical services across the nation. While EMS system design varies greatly, in almost all cases there is participation by both public and private entities. For this reason, it is critical that a strong partnership exist between public and private first responders and those who manage the incident command system. Furthermore, the

successful management of any disaster response is directly related to the coordination of all assets being deployed for mitigation of serious injury and death.

V. Commitment to National Incident Management System

As the Department of Homeland Security and FEMA implement the National Response Plan, the AAA has been working with our members to assure that our providers are compliant with the ICS training requirements established by the National Incident Management System (NIMS). We support the full implementation of NIMS as it establishes standardized incident management processes, protocols, and procedures that all responders--Federal, state, tribal, and local--will use to coordinate and conduct response operations. As stated by the NIMS Integration Center, we agree that national preparedness and readiness in responding to and recovering from an incident will significantly improve once all of the Nation's emergency responders and their authorities will be using a common language and set of procedures.

VI. Challenges of Incident Command, Control and Communications

The response by ambulance service providers locally and from across the country to the catastrophes of Hurricanes Katrina and Rita represents the very best of the EMS community. The Federal Emergency Management Agency requested AAA's assistance in providing member companies to respond to Louisiana to assist the local EMS effort. AAA member companies responded to this request by dispatching over 215 ambulances to the region. A similar request of the Association resulted in 250 ambulances being dispatched to Texas in anticipation of Hurricane Rita. While this "emergency coordination" effort has not historically been a core competency of the American Ambulance Association, upon being alerted, member companies responded professionally and expeditiously.

The American Ambulance Association has been requested to present its perspective in various forums as preparations for Incidents of High Consequence are being considered. In all cases, the AAA has offered four key components that should be addressed for a successful response and incident command capability. The components are as follows:

- Standardized and coordinated training;
- Personal Protective Equipment (clothing/respirators);
- Interoperable communications and Tactical equipment; and,
- Caches of medications/medical equipment for Incident of High Consequence.

VII. Specific Policy Challenges and Recommendations

Because of the nature of our services, members of the American Ambulance Association have been part of the first responder team to America's most devastating disasters, including September 11, the anthrax attacks, Hurricane Katrina, Hurricane Rita and numerous other regional and multi-state mass casualty events. Based on this extensive experience, we offer the following recommendations to the challenges we face in responding to the medical needs of our patients and communities, and to ensure the effective participation of ambulance providers in the National Incident Management System:

Challenge #1: Planning, Exercises and Mutual Aid Agreements – Ambulance providers operate at the intersection of the public health, public safety and health care fields, and, there is great diversity in the types of providers delivering ambulance services and the designs of those delivery systems. This diversity contributes to the fact that many ambulance services are sometimes excluded from local and state emergency preparedness and response activities. Furthermore, there are hurdles associated with complying with FEMA's general requirement to obtain mutual aid agreements prior to an event in order to be eligible for federal disaster reimbursement. Ambulance providers respond to mutual aid requests from long distances—including neighboring cities, counties and even states. It is difficult for a local ambulance provider to secure prior mutual aid agreements with every local community that may request services in the future.

Recommendation #1: As recent events of national consequence have demonstrated, government and non-government emergency medical services are an essential asset in the evacuation, response and recovery phases of a national disaster. Government and non-government ambulance services must be fully integrated in the planning, training and exercise activities at the local, state and federal level. Practical mechanisms must be instituted to streamline and document all mutual aid requests for assistance. As local, regional and state mutual aid plans are strengthened and broadened, the planning process should formalize mutual aid agreements with all potential responders and service providers. These are critical first steps in assuring that the goals of the National Incident Management System are achieved.

Challenge #2: Communications Interoperability – Based on a recent AAA membership survey, AAA members have reported that communications systems and equipment remain a significant operational need. In many communities, ambulance service providers face challenges obtaining access to radio frequencies. Studies clearly show the lack of a compatible spectrum as well as a spectrum that is actually available to local emergency responders, including emergency medical service (EMS) providers. Despite the spectrum documented by the Federal Communications Commission, across the nation currently only two frequencies are dedicated to EMS (a local EMS frequency and a national EMS frequency). During recent incidents of major consequence, AAA members experienced serious gaps in maintaining communications with incident command authorities.

Recommendation #2: Additional spectrum must be made available to government and non-government emergency medical service providers and providers must be involved in the communications interoperability planning activities at the local, state, regional and national level. Therefore, government and non-government emergency medical service providers must be eligible for grants to assure communications systems support our critical public safety mission. Access to communications equipment and systems is a critical component of any effective incident command system.

Challenge #3: On Scene Resources – Many ambulance service personnel that responded to recent major incidents did not have access to the appropriate personal protective equipment necessary for the environments in which they would be operating including hazardous scenes and toxic flood waters. Ambulance refueling, repair and restocking are important considerations as well.

Recommendation #3: To provide an effective response and to protect the health and safety of our personnel, all medics, including those who have the potential to respond in a mutual aid capacity, must be protected. Personnel must have access to and must be trained on the appropriate procedures for use of personal protective equipment that may include tyvec suits, gloves, masks, hard hats, bunker suits and bio-hazard storage and disposal equipment. Procedures must be developed to assure access to vaccines and antidotes when necessary. In order for on scene personnel to be effective in the incident command structure, these on scene resources are essential.

VIII. "Best Practices" Recommendations on Incident Command Systems

In order to achieve a fully integrated national emergency response system that is adaptable to any terrorist attack and all types of national disasters, the following best practice components are essential.

This list was developed by the AAA to assist local, state and federal officials, in addition to ambulance service providers, in planning, training and equipping the nation's ambulance services in accordance with the National Incident Management System.

Incident Command Structure and Emergency Management System: Ambulance service providers should be integrated into the overall incident command structure. For resource planning, legal and reimbursement purposes, local officials must document requests for all types of assistance from ambulance providers. Services requested may include, but are not limited to: patient triage, treatment and transport; medical stand-by and first aid services on-scene, at disaster shelters or at first aid stations; requests for additional medical personnel, supplies and equipment; non-emergency transport and redistribution of patients to free-up receiving hospital bed-space; and other emergency services. State and local emergency managers must integrate ambulance providers into each phase of the emergency management planning process: mitigation, preparedness, response, and recovery and include an ambulance representative in the emergency operations center.

Community-Based Planning: Ambulance service providers must be represented in the planning processes at the local, state and federal level. These processes must facilitate coordination and integration among various public and private (non-profit and for-profit) organizations in order to maximize the effectiveness of all local, regional (such as mutual aid), state and federal resources. Logistical planning must assure the ability to sustain long-term disaster operations and critical support functions, including mental health and CISD (critical incident stress debriefing) support of workers and their families. Ambulance services must appropriately interface with public health, law enforcement, fire suppression, hazardous materials and other responding agencies to hazardous scenes.

Personnel Protection & Safety: By definition, first responders, including emergency medical service and ambulance service personnel (i.e., ambulance medics), are the first on the scene of an emergency incident. Past experience has shown that proper equipment, training and procedures are necessary to prevent well-meaning rescuers from becoming victims themselves, especially in the case of a biological, chemical, radiological or nuclear attack. To provide an effective response, to serve our communities and most importantly, to protect the health and safety of our

personnel, all medics, including those who have the potential to respond in a mutual aid capacity, must be protected. Personnel must have access to and must be trained on the appropriate procedures for use of personal protective equipment that may include tyvec suits, gloves, masks, hard hats, bunker suits and bio-hazard storage and disposal equipment. Procedures must be developed to assure access to vaccines and antidotes when necessary.

Training, Exercises and Continuing Education: Ambulance services (both emergency 9-1-1 units and units regularly performing non-emergency inter-facility transports) immediately become "first responders" in the early stages of an emergency incident. Proper training of all personnel with the potential to respond to disaster and terrorist incidents is essential to assure effective use of resources and to prevent crews from inadvertently becoming casualties themselves. Each local ambulance service provider that is listed as a disaster resource by the local community's "emergency operations officials" must be included in training programs. The following types of training should be considered: nuclear, biological, chemical and radiological terrorism awareness training, incident command system procedures, biological/chemical symptom recognition and protocols, multi-casualty incident drills and exercises, and cross-training of medics as public health workers. Plans should include provisions for training updates, new employee training and integration with continuing education programs.

Communication System: All scene responders, including ambulance medics, must have access to improved on-scene communications, such as radios and cellular telephones, to assure communication between agencies. Larger incidents involve even greater numbers of emergency response personnel that often must respond from long distances. Response personnel must have equipment, systems and procedures that assure seamless on-scene communications. Emergency medical dispatchers must be trained to screen for biological and chemical events. Other considerations include planning for additional radios and cellular phones and a back-up communication center in the event all or parts of the communications center or system is inoperable.

Disease Surveillance and Reporting System: In the case of chemical, biological, radiological and nuclear weapons, the emergency medical services system, and specifically local ambulance dispatch (call-taking) centers, may be one of the early points of detection. Proper reporting and analysis of this crucial information can assist in the detection, identification and early implementation of patient triage and treatment protocols. Procedures must be implemented to coordinate and integrate these essential assets with the local public health department's disease symptom surveillance and identification system. Recent computer-aided dispatch software enhancements enable emergency medical dispatchers to identify sudden increases in certain caller complaints in real time. Ambulance medics could be cross-trained for various public health functions according to response plans.

Facilities, Equipment and Vehicles: Ambulance service providers need to plan and develop stockpiles of secure food, water, personal items, uniforms, and bedding for events that require sustained operations requiring maximum staffing. Operations facilities may be utilized as personnel sleeping quarters. The needs of their families are also important to assure personnel can focus on the community's needs. Ambulance service providers will need to establish a decontamination station for personnel, vehicles, supplies and equipment and appropriate disposal of contaminated uniforms, medical supplies, patient bedding and other materials. Ambulance

services must develop procedures for securing facilities, equipment and vehicles to assure they are not sabotaged, stolen or misused.

Medical Supplies and Medications: Before additional federal stockpiles (referred to as "Push Packs" under the proposed plan) arrive in affected communities, local first responders, public health and health care providers will need the capacity to distribute adequate levels of medical supplies and medications during the first 12 hours of an incident. The local and regional planning and funding process must account for these purchase, storage and distribution costs. Mass-casualty incidents will require additional pharmaceuticals, such as, Valium, Atropine, antidote kits, Mark 1 kits and an antibiotic (i.e., Cipro) cache for field personnel. Additional medical supplies will also be required, such as, intubation, bag mask, and nebulizer supplies; sheets, drapes, and poly masking tape for patient packaging and additional immunization supplies.

Public Education: Through the appropriate local, state and federal entities, the public must be educated before an emergency incident, and must receive regular information updates during an incident especially if there is a suspected biological, chemical or radiological exposure. The focus of the information should include: *what* to do in an emergency; *where* disaster shelters are located; *where* to receive treatment and *where not* to receive treatment (in order to contain and prevent further contamination); and, *which* agencies to contact for more information or to report critical information to emergency officials. The public has learned to rely on the local 9-1-1 system and the community's emergency response agencies for information and these agencies should play a key role in calming the public's understandable fears and anxiety and to correct false information.

Mutual Aid Agreements: Generally, the larger the incident, man-made or natural, the greater the scope of mutual aid response required. As a result of large mass casualty incidents, ambulance providers respond to mutual aid requests from long distances—including neighboring cities, counties and even states. It is impossible for a local ambulance provider to secure prior mutual aid agreements with every local community that *may* request services in the future. Therefore, practical mechanisms must be instituted to streamline and document all mutual aid requests for assistance, especially when there is no time to work out the financial details before a response is initiated. As local, regional and state mutual aid plans are strengthened and broadened, the planning process should formalize mutual aid agreements, including financial arrangements, with all potential responders and service providers.

Initial Emergency Preparedness Funding: Because existing resources, surge capacities and community needs will vary, each community's specific funding requirements will be unique. As an example, however, one community recently developed a local plan for response to weapons of mass destruction. According to this plan, the local emergency ambulance provider's funding needs for planning, employee training, personnel protective equipment, medical supplies and medications equaled approximately $5 per resident for a community of 285,000 residents, totaling approximately $1.4 million in start-up costs. Each community will also need to budget for the ongoing costs of training, equipment replacement and repurchase of expired medications. Federal funds must flow to all local entities in the emergency response system, including private (non-profit and for-profit) service providers. Immediate and sustained funding will also be required to increase and maintain the health care capacity (or "surge capacity") needed to

respond to mass casualty incidents of various types. Program funding should factor in the ongoing costs of the planning and training process that is continuously reviewed and refined.

Emergency Incident Reimbursement: Each organization that responds to a natural disaster or terrorist incident will incur costs for personnel salaries; overtime expenses; fuel; travel expenses; specialized equipment such as generators; drugs and supplies; replacement costs for damaged or lost equipment; supplies and equipment for decontamination stations and other direct costs. Even though the service may have performed flawlessly in the public's interest, local emergency responders can very quickly face financial devastation as a result. Under existing laws governing federally declared disasters (i.e., the Stafford Act), all types of ambulance service providers (including private non-profit and for-profit services) are eligible for federal reimbursement under both "emergency protective measures" and "emergency work" provisions. Ambulance services can also be reimbursed as an independent contractor under provisions regarding "use of local firms and individuals. Local and state officials must assist ambulance providers involved in a disaster response with the process of submitting requests for federal reimbursement.

IX. Conclusion

In conclusion, as demonstrated most recently in the response to Hurricanes Katrina and Rita, government and non-government emergency medical service providers are a critical component of the state, local and the national response to catastrophic events. In these types of situations, all ambulance service providers, regardless of provider type or whether the units are emergency or non-emergency, become potential first responders.

Ambulance service providers stand ready to assist in responding to future catastrophic events and assisting in the development of comprehensive and integrated pre-planned response guidelines and protocols. However to assure effectiveness, the local, state and federal planning process must account for the resources needed by all America's emergency medical services systems and ambulance service providers based on the following guiding principles:

- Assure the safety of ambulance service personnel and ambulance patients, and the security of ambulance facilities, supply inventories and vehicles;
- Integrate and effectively utilize local ambulance services in the local, state and federal incident management and emergency management systems;
- Establish timely and equitable funding mechanisms to support and maintain the essential capabilities of the first responder system

I again thank Chairman Reichert, Ranking Member Pascrell and members of the Subcommittee on Emergency Preparedness, Science and Technology for the opportunity to testify on this important issue.

I will be more than happy at the appropriate time to answer questions that Subcommittee members have for me.

Thank you.